



AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

April 11, 2019

Mr. Dustin Redlein, Manager
7 Royce Street
7 Royce Street
Rutland, VT 05701-4432

Dear Mr. Redlein:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 25, 2019**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in cursive script, appearing to read "Pamela M. Cota".

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0617	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/25/2019
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NAME OF PROVIDER OR SUPPLIER

7 ROYCE STREET

STREET ADDRESS, CITY, STATE, ZIP CODE

7 ROYCE STREET
RUTLAND, VT 05701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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R100 Initial Comments:

R100

An unannounced on-site entity report complaint investigation was conducted by the Division of Licensing and Protection on 3/25/19. There were regulatory violations cited.

R206 V. RESIDENT CARE AND HOME SERVICES
SS=D

R206

5.18 Reporting of Abuse, Neglect or
Exploitation

5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and record review, the facility failed to report suspected cases of verbal and physical abuse of two residents, Resident #1 and #2. Findings include:

A documented altercation occurred between Resident #1 and #2 on 12/12/18, in which Resident #1 slapped and scratched Resident #2, following a verbal altercation. The staff on duty at the time of the altercation completed the necessary incident report per the facility policy and documented the incident, but failed to notify the house manager or the house supervisor. The house supervisor reported the incident to the State Agent after learning of the altercation on 12/19/18. Interview with staff that was on duty at the time of the incident, confirmed on 3/25/18 at 10:39 AM that the State Agent had not been

see attached

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Director/Manager

(X6) DATE

4/9/19

STATE FORM

C2T711

If continuation sheet 1 of 3

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0617	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/25/2019
NAME OF PROVIDER OR SUPPLIER 7 ROYCE STREET		STREET ADDRESS, CITY, STATE, ZIP CODE 7 ROYCE STREET RUTLAND, VT 05701		
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R206	Continued From page 1 notified during the time requirements following the incident. S/he stated that s/he did not feel that it needed to be reported. Further record review of Resident #2, documentation of staff presents that on 12/8/18 the resident had called Resident #1 a "baby" and a "jackass" prior to hitting Resident #1 on the back. The record review also presented that on 12/9/18 Resident #2 was yelling at Resident #1 about not being able to go home and again called him/her a "baby" and a "jackass" and made threats to hit Resident #1. Documentation for 12/21/18 states that Resident #2 was yelling at Resident #1 and came from the living room to the dining room and slapped Resident #1 on the back. An entry dated 12/30/18 presents that Resident #2 followed Resident #1 to the bathroom and hit him/her on the back. Per interview with caregiver on 3/25/18 at 10:16 AM, stated that the slaps were open hand and it wasn't a tap or a push away kind of slap. The caregiver further stated that s/he had not reported the incidents to the management or to the State Agent.	R206		
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record reviews, the	R224		

R - 206 POC accepted 4/10/19
B. Borkell, RW / S. Bury, RW
see attached document

see attached

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0617	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 03/25/2019
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R224	Continued From page 2 facility failed to keep two residents, Resident #1 and #2, free from resident to resident verbal or physical abuse on six separate occasions. Findings include: A documented altercation occurred between Resident #1 and #2 on 12/12/18, in which Resident #1 slapped and scratched Resident #2, following a verbal altercation. Per interview with staff, the two residents argue with each other all the time and threaten each other. Further record review of Resident #2, documentation of staff presents that on 12/8/18 the resident had called Resident #1 a "baby" and a "jackass" prior to hitting Resident #1 on the back. The record review also presented that on 12/9/18 Resident #2 was yelling at Resident #1 about not being able to go home and again called him/her a "baby" and a "jackass" and made threats to hit Resident #1. Documentation for 12/21/18 states that Resident #2 was yelling at Resident #1 and came from the living room to the dining room and slapped Resident #1 on the back. An entry dated 12/30/18 presents that Resident #2 followed Resident #1 to the bathroom and hit him/her on the back. Per interview with the house supervisor on 3/25/19 at 8:30 AM, s/he stated that it is not unusual that the two residents yell and argue with each other. Per interview with caregiver on 3/25/18 at 10:16 AM, stated that the slaps were open hand and it wasn't a tap or a push away kind of slap. During interview with staff at 10:46 AM, the staff the two residents often scream and yell at each other further stated that they will sometimes slap at each other and staff needs to intervene.		R224	R224 POC accepted 4/10/19 B. Borkell EV, /s Penny, EV See attached document	

Community Access Program



Community Care Network
Rutland Mental Health Services
thriving community, empowered lives.

April 3rd, 2019

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306

Re: Plan of Correction for 7 Royce Street

On March 25th, 2019 the Division of Licensing and protection completed an investigation. The survey revealed deficiencies at the Royce Street Level III Residential Care home. The following is our plan of correction for the deficiencies identified in the survey.

R206 V. Resident Care and Home Services

1. The action taken to correct the deficiency will be to retrain all staff on mandated reporting.
2. The supervisor met with all staff individually, and held a staff meeting on 4/3/2018, to retrain and discuss mandatory reporting.
3. The supervisor, daily will check the ISA documentation to assure all incidents are reported appropriately.
4. This was completed by 4/3/2018.

R-206 POC accepted 4/10/19 B. Barkell RW/S. Perry RW

R224 VI. Residents' Rights

1. The action taken to correct the deficiency is to assure all Residents are free of abuse.
2. When Resident #1 and Resident #2 are in the same room together, one staff will be in the same room with them at all times. Staff will follow Resident #1's behavioral support plan as written to prevent further escalation. Where there is a conflict between resident #1 and resident #2, staffs will immediately assess the situation to deescalate and redirect to prevent the chance of abuse.
3. The supervisor, daily will check the ISA documentation, to assure all incidents are reported appropriately.
4. This has been an immediate correction.

R-224 POC accepted 4/10/19 B. Barkell RW/S. Perry RW

Sincerely,

A handwritten signature in black ink, appearing to read "Dustin Redlein".

Dustin Redlein
Director of Residential
and Specialized Supports
House Manager